Federal Communications Commission.

Marlene H. Dortch,

Secretary,

Office of the Secretary,

Office of Managing Director.

[FR Doc. 2010–14787 Filed 6–17–10; 8:45 am]

BILLING CODE 6712–01–S

FEDERAL DEPOSIT INSURANCE CORPORATION

Sunshine Act Meeting

Pursuant to the provisions of the "Government in the Sunshine Act" (5 U.S.C. 552b), notice is hereby given that the Federal Deposit Insurance Corporation's Board of Directors will meet in open session at 10 a.m. on Tuesday, June 22, 2010, to consider the following matters:

Summary Agenda: No substantive discussion of the following items is anticipated. These matters will be resolved with a single vote unless a member of the Board of Directors requests that an item be moved to the discussion agenda.

Disposition of minutes of previous Board of Directors' Meetings.

Summary reports, status reports, reports of the Office of Inspector General, and reports of actions taken pursuant to authority delegated by the Board of Directors.

Discussion Agenda:

Memorandum and resolution re: Final Rule: Temporary Liquidity Guarantee Program.

Memorandum re: Deposit Insurance Fund Loss, Income and Reserve Ratio Projection Update for the Restoration Plan.

The meeting will be held in the Board Room on the sixth floor of the FDIC Building located at 550 17th Street, NW., Washington, DC.

This Board meeting will be Webcast live via the Internet and subsequently made available on-demand approximately one week after the event. Visit *http://www.vodium.com/goto/fdic/boardmeetings.asp* to view the event. If you need any technical assistance, please visit our Video Help page at: *http://www.fdic.gov/video.html.*

The FDIC will provide attendees with auxiliary aids (*e.g.,* sign language interpretation) required for this meeting. Those attendees needing such assistance should call (703) 562–6067 (Voice or TTY), to make necessary arrangements.

Requests for further information concerning the meeting may be directed to Mr. Robert E. Feldman, Executive Secretary of the Corporation, at (202) 898–7043.

Dated: June 15, 2010.

Federal Deposit Insurance Corporation.

Robert E. Feldman,

Executive Secretary.

[FR Doc. 2010–14906 Filed 6–16–10; 4:15 pm]

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FEDERAL MARITIME COMMISSION

Sunshine Act Meeting

AGENCY HOLDING THE MEETING: Federal Maritime Commission.

TIME AND DATE: June 23, 2010—10 a.m.

PLACE: 800 North Capitol Street, NW., First Floor Hearing Room, Washington, DC.

STATUS: Part of the meeting will be in Open Session and the remainder of the meeting will be in Closed Session.

MATTERS TO BE CONSIDERED:

Open Session

1. Fact Finding No. 27: Complaints or Inquiries from Individual Shippers of Household Goods or Private Automobiles

Closed Session

1. Fact Finding Investigation No. 26: Vessel Capacity and Equipment Availability in the United States Export and Import Liner Trades—Discussion of the Fact Finding Officer's Interim Report Findings

2. Staff Briefing and Discussion Regarding Passenger Vessel Financial Responsibility Notice of Inquiry Information Collection

CONTACT PERSON FOR MORE INFORMATION: Karen V. Gregory, Secretary, (202) 523–5725.

Karen V. Gregory,

Secretary.

[FR Doc. 2010–14939 Filed 6–16–10; 4:15 pm]

BILLING CODE 6730–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10219, CMS–10317, CMS–10069, CMS–367, CMS–10068, CMS–R–13 and CMS–2728]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS) is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Healthcare Effectiveness Data and Information Set (HEDIS®) Data Collection for Medicare Advantage; *Use:* Medicare Advantage Organizations (MAOs) and section 1876 cost contracting managed care are required to submit HEDIS® data to CMS on an annual basis. Sections 422.152 and 422.516 of Volume 42 of the Code of Federal Regulations (CFR) specify that Medicare Advantage organizations must submit performance measures as specified by the Secretary of the Department of Health and Human Services and by CMS. These performance measures include HEDIS®. HEDIS® is a widely used set of health plan performance measures utilized by both private and public health care purchasers to promote accountability and to assess the quality of care provided by managed care organizations. HEDIS® is designed for private and public health care purchasers to promote accountability and to assess the quality of care provided by managed care organizations. CMS is committed to the implementation of health care quality assessment in the Medicare Advantage program. In January 1997, CMS began requiring Medicare managed care organizations (MCOs) (these organizations are now called Medicare Advantage organizations or MAOs) to collect and report performance measures from HEDIS® relevant to the Medicare managed care beneficiary population.

The data are used by CMS staff to monitor MAO performance and inform audit strategies, and inform beneficiary choice through their display in CMS' consumer-oriented public compare tools and Web sites. Medicare Advantage organizations use the data for quality

assessment and as part of their quality improvement programs and activities. Quality Improvement Organizations (QIOs) and CMS contractors use HEDIS® data in conjunction with their statutory authority to improve quality of care, and consumers who are making informed health care choices. *Form Number:* CMS–10219 (OMB#: 0938–1028); *Frequency:* Yearly; *Affected Public:* Business or other for-profits and not-for-profit institutions; *Number of Respondents:* 483; *Total Annual Responses:* 483; *Total Annual Hours:* 154,560. (For policy questions regarding this collection contact Lori Teichman at 410–786–6684. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* New collection; *Title of Information Collection:* The Medicare Acute Care Episode Demonstration; *Use:* Medicare's Acute Care Episode (ACE) Demonstration is authorized under Section 646 of the MMA (Pub. L. 108–173) that amends title XVIII (42 U.S.C. 1395) of the Social Security Act. The ACE Demonstration stems from a longstanding need for improved quality of care and decreased costs.

As costs have risen over time, ideas to improve Medicare payment systems and efficiency have been developed. Moving from a cost based payment arrangement to a hospital prospective payment system has dramatically simplified billing and coding procedures and generated important impacts on Medicare savings and quality of care measures. While prospective hospital payments based on diagnosis related groups (DRGs) for acute care was the innovation of the 1980s, the Federal government has taken interest in value-based purchasing (VBP) in recent years. The VBP strategy rests on linking hospital performance to financial incentives. VBP has been heralded as a method to increase efficiency and quality of care while decreasing cost. In addition to its use as a payment system, the VBP strategy allows for performance scoring of hospitals based on the designated VBP quality measures.

In the case of the ACE Demonstration, the test has been designed to address the use of a global payment for an episode of care as an alternative approach to payment under traditional Medicare. The episode of care is defined as the bundle of Part A and Part B services provided during an inpatient stay for Medicare FFS beneficiaries for included Medicare severity-based diagnosis-related groups (MS–DRGs). The ACE Demonstration is limited to health care groups (i.e., physician-hospital organizations—PHOs) with at least one physician group and at least one hospital and that routinely provide care for at least one group of selected orthopedic or cardiac procedures:

- Hip/knee replacement or revision surgery; and/or
- Coronary artery bypass graft (CABG) surgery or cardiac intervention procedure (pace-maker and stent placement).

Evaluation of ACE will reveal whether the use of a bundled payment system will produce savings for Medicare for episodes of care involving the included DRGs. In addition to cost savings, the evaluation will assess changes to quality of care at the demonstration sites; whether or not the payment system creates better collaboration between physicians and facilities leading to higher quality patient care. *Form Number:* CMS–10317 (OMB#: 0938–New); *Frequency:* Occasionally; *Affected Public:* Individuals or households; *Number of Respondents:* 509; *Total Annual Responses:* 509; *Total Annual Hours:* 763.5. (For policy questions regarding this collection contact Jesse Levy at 410–786–6600. For all other issues call 410–786–1326.)

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Waiver Demonstration Application; *Use:* The currently approved application has been used for several congressionally mandated and Administration high priority demonstrations. The standardized proposal format is not controversial and will reduce burden on applicants and reviewers. Responses are strictly voluntary. The standard format will enable CMS to select proposals that meet CMS objectives and show the best potential for success. *Form Number:* CMS–10069 (OMB#: 0938–0880); *Frequency:* Once; *Affected Public:* Private Sector: Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 75; *Total Annual Responses:* 75; *Total Annual Hours:* 6,000. (For policy questions regarding this collection contact Diane Ross at 410–786–1169. For all other issues call 410–786–1326.)

4. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicaid Drug Program Monthly and Quarterly Drug Reporting Format; *Use:* In order for payment to be made under Medicaid, the drug labeler must complete and sign a drug rebate agreement and fill in the information on the related documents. The Patient Protection and Affordable Care Act of 2010 added two new data elements to potentially be reported by manufacturers. In addition, the Food and Drug Administration has informed us that "DESI" is now obsolete; therefore, we are replacing it with a more appropriate "rebate eligibility code" that will more accurately describe how a product is eligible for coverage under the drug rebate program. *Form Number:* CMS–367 (OMB#: 0938–0578); *Frequency:* Monthly and Quarterly; *Affected Public:* Private Sector: Business or other for-profits; *Number of Respondents:* 580; *Total Annual Responses:* 9,280; *Total Annual Hours:* 137,344. (For policy questions regarding this collection contact Samone Angel at 410–786–1123. For all other issues call 410–786–1326.)

5. *Type of Information Collection Request:* Reinstatement with change of a previously approved collection; *Title of Information Collection:* Beneficiary Customer Service Feedback Survey; *Use:* The Centers for Medicare & Medicaid Services (CMS) stresses a continuing need for setting customer service goals that include providing accurate, timely, and relevant information to its customers. With these goals in mind, the Division of Medicare Ombudsman Assistance (DMOA) needs to periodically survey its customers that correspond with CMS to ensure that the needs of Medicare beneficiaries are being met. This survey will be used to measure overall satisfaction of the customer service that the DMOA provides to Medicare beneficiaries and their representatives. The need for this previously OMB approved information collection is to further meet the customer service goals that the CMS has established and to continue to create a rapport within the Medicare community. *Form Number:* CMS–10068 (OMB#: 0938–0894); *Frequency:* Quarterly; *Affected Public:* Individuals and Households; *Number of Respondents:* 2,242; *Total Annual Responses:* 2,242; *Total Annual Hours:* 224. (For policy questions regarding this collection contact Nancy Conn at 410–786–8374. For all other issues call 410–786–1326.)

6. *Type of Information Collection Request:* Reinstatement with change of a previously approved collection; *Title of Information Collection:* Conditions of Coverage for Organ Procurement Organizations and Supporting Regulations in 42 CFR, Sections 486.301–.348; *Use:* Section 1138(b) of the Social Security Act, as added by section 9318 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509), sets forth the statutory qualifications and requirements that OPOs must meet in order for the costs of their services in procuring organs for transplant centers to be reimbursable

under the Medicare and Medicaid programs. An OPO must be certified and designated by the Secretary as an OPO and must meet performance-related standards prescribed by the Secretary. The corresponding regulations are found at 42 CFR Part 486 (Conditions for Coverage of Specialized Services Furnished by Suppliers) under subpart G (Requirements for Certification and Designation and Conditions for Coverage: Organ Procurement Organizations).

Since each OPO has a monopoly on organ procurement within its donation service area, CMS must hold OPOs to high standards. Collection of this information is necessary for CMS to assess the effectiveness of each OPO and determine whether it should continue to be certified as an OPO and designated for a particular donation service area by the Secretary or replaced by an OPO that can more effectively procure organs within the donation service area. *Form Number:* CMS–R–13 (OMB#: 0938–0688); *Frequency:* Occasionally; *Affected Public:* Not-for-profit institutions; *Number of Respondents:* 79; *Total Annual Responses:* 79; *Total Annual Hours:* 15,178. (For policy questions regarding this collection contact Diane Corning at 410–786–8486. For all other issues call 410–786–1326.)

7. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* End Stage Renal Disease Medical Evidence Report Medicare Entitlement and/or Patient Registration; *Use:* The End Stage Renal Disease (ESRD) Medical Evidence Report is completed for all ESRD patients either by the first treatment facility or by a Medicare-approved ESRD facility when it is determined by a physician that the patient's condition has reached that stage of renal impairment that a regular course of kidney dialysis or a kidney transplant is necessary to maintain life. The data reported on the CMS–2728 is used by the Federal Government, ESRD Networks, treatment facilities, researchers and others to monitor and assess the quality and type of care provided to end stage renal disease beneficiaries. The data collection captures the specific medical information required to determine the Medicare medical eligibility of End Stage Renal Disease claimants. *Form Number:* CMS–2728 (OMB#: 0938–0046); *Frequency:* Occasionally; *Affected Public:* Individuals or households; *Number of Respondents:* 100,000; *Total Annual Responses:* 100,000; *Total Annual Hours:* 75,000. (For policy questions regarding this collection contact Connie Cole at 410–786–0257. For all other issues call 410–786–1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web site at *http://www.cms.hhs.gov/PaperworkReductionActof1995,* or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov,* or call the Reports Clearance Office on (410) 786–1326.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by August 17, 2010:

1. *Electronically.* You may submit your comments electronically to *http://www.regulations.gov.* Follow the instructions for "Comment or Submission" or "More Search Options" to find the information collection document(s) accepting comments.

2. *By regular mail.* You may mail written comments to the following address:

CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: June 15, 2010.

Michelle Shortt,

Director, Regulations Development Group, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2010–14781 Filed 6–17–10; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10179, CMS–R–234, CMS–2540–10, CMS–10108, CMS–10315, CMS–10302, CMS–2744 and CMS–2746]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the Agency's function; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. T*ype of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Requests by Hospitals for an Alternative Cost-to-Charge Ratio. *Use:* Section 1886(d)(5)(A) of the Act provides for additional Medicare payments to Inpatient Prospective Payment System (IPPS) hospitals for cases that incur extraordinarily high costs. To qualify for outlier payments, a case must have costs above a predetermined threshold amount (a dollar amount by which the estimated cost of a case must exceed the Medicare payment). Hospital-specific cost-to-charge ratios are applied to the covered charges for a case to determine the estimated cost of the case. In general, additional outlier payments for eligible cases are made based on a marginal cost factor of 80 percent, i.e. a fixed percentage of the costs. Therefore, if the estimated cost of the case exceeds the Medicare payment for that discharge plus the outlier threshold, generally Medicare will pay the hospital 80 percent of the excess amount. The outlier threshold is updated annually at the beginning of the Federal Fiscal Year. *Form Number:* CMS–10179 (OMB#: 0938–1020); *Frequency:* Occasionally; *Affected Public:* Private Sector and Business or other for-profits, Not-for-profit institutions; *Number of Respondents:* 18; *Total Annual Responses:* 18; *Total Annual Hours:* 144. (For policy questions regarding this collection contact Michael Treitel at 410–786–4552. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Subpart D—Private Contracts and Supporting Regulations contained in 42 CFR 405.410, 405.430, 405.435, 405.440, 405.445, and 405.455. *Use:* Section 4507